The Therapeutic Aspect of Some Ovarian Disorders.

BY

EDWARD W. JENKS, M.D., LL.D.,
DETROIT, MICH.

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The brief paper which it is my desire to present on the above topic is not for the purpose of offering any new surgical operation or mode of treatment, but to direct attention to the merits and demerits of familiar and well-known modes of treating certain ovarian diseases. Since my first ovariotomy in 1868, I have, in each succeeding year, made various abdominal operations which are now classed under the one general title of laparotomy; and therefore I think it is not inappropriate for me to say that it is from the standpoint of the surgeon rather than that of the physician that the subject of this paper is considered.

It is generally conceded that it is mostly for the removal of the ovaries that laparotomies are made, therefore all references in this paper to abdominal surgery bear upon its relation to the ovaries or Fallopian tubes.

Many gynecologists have become distinguished in abdominal surgery, and it is with pride I state that nowhere else, in my opinion, are there to be found as many skilful and successful abdominal surgeons as among the Fellows of this Society, therefore I know I am not reading to reckless operators. It is an incontrovertible fact, however, that there are many reputable general and gynecological surgeons that are unsuccessful laparotomists, either by their inaptitude for that kind of surgical work or other causes needless to enumerate.

The brilliant achievements of abdominal surgery within the past few years have fairly astonished the medical world. Current medical literature teems with articles upon this topic with reports of cases and modes of operating. The percentage of recoveries, with successful operators, has become so large that its recital would have seemed a fairy tale in the days when some of the founders of this Society began their work in this field. But there is always a spot on the face of perfection. The outward appearance of ease, the repression of the many difficulties and much care by which these great percentages have been obtained, has been the *ignis fatuus* of the inexperienced.

While to do many operations and to have a large per cent. of recoveries is a laudable ambition, there is still a higher aim; that is, to cure the patient, and all of us know, if we were willing to acknowledge it, that to operate and to cure have not ever been synonymous terms. This is a central question around which many things turn.

In most towns of our country it is an unusual meeting of their medical societies where recently removed ovaries are not exhibited. This exhibition is not confined to special societies, nor, unhappily, to members who are known to be experienced laparotomists, but not unfrequently to physicians of limited experience in every department of medicine and surgery. The removal of a woman's ovaries seems to be looked upon as a trivial affair, a matter of such little importance that often a serious protest against this mutilation of women will be met with a flippant rejoinder. It is thus that abdominal surgery is brought into disrepute and sometimes valuable lives sacrificed.

This conviction, I think, was fully awakened some four years ago while in consultation in a remote district. The gynecologist (at least his professional card designated him as one) called my attention with considerable flourish to some ovaries and tubes in a bottle conspicuously placed on a table in his consulting-room; he informed me how he had arrived at a

diagnosis in this case, advised laparotomy, and then described minutely the *technique* of the operation. I was unable to observe, although it might have been shown by the microscope, any pathological condition calling for their extirpation. I supposed from the doctor's enthusiasm that the patient must have been correspondingly benefited, but in response to my inquiry on that point he replied: "Oh! she died on the third day."

There are undoubtedly many fatal cases of laparotomy of which there are no publications and of which the medical world has no knowledge. There are also many instances of recovery from operations where the patient is not benefited in the least; I am free to confess that I have had some in my own practice.

I am convinced from my own observation that some patients whom the gynecologist at the first examination believes can only be cured by the removal of one or both ovaries and tubes often recover while the operation is being postponed until a more convenient season arrives. I have seen this in so many instances, some having been referred to me for the purpose of being operated upon, that, day by day, the conviction has grown stronger upon me that an earnest plea for the salvation of ovaries should emanate from gynecologists, or, rather, laparotomists themselves.

The reason for calling attention to some of these points is that it seems as if the time had arrived when every conscientious physician and surgeon should endeavor to discountenance the removal of women's ovaries to the extent it is now practised, not only in our large cities, but in every village and farming community of our country, by every one considering himself capable of wielding a knife or tying a ligature. There would be less ground for this assertion if such surgical operations were confined to those who, by reason of education, observation, and experience, had become astute diagnosticians and skilful surgeons in this specialty. I have frequently heard it asserted, and it is doubtless true, that

many who are themselves successful have refrained from expressing their views in their own local medical societies as to the requisite qualifications of the skilful abdominal surgeon, lest they be considered egotistical or seeking to monopolize the surgical work of others.

I would not, if it were possible, detract a particle from the justly earned reputation of our distinguished countryman and the operation which bears his name, for I believe that Battey's operation is requisite in a limited number of cases, nor can it be denied that the ovaries and Fallopian tubes must in some instances be removed to secure the establishment of health; but is it not equally true that many women have been deprived of their ovaries without benefit, and many others advised to have them removed that have ultimately been restored to health without the knife being used?

It is not uncommon for us to learn more from our mistakes and errors in judgment than from our most brilliant successes, and from many of my own mistakes and errors I trust I have gained some useful knowledge; and my criticism, if it can thus be termed, is upon myself rather than others. I have removed ovaries and tubes for pain, but neither among my own patients nor any coming under my observation have the results been satisfactory. The same surgical operation for mental disorders has in my practice been scarcely more gratifying.

It is evident to me that anæmia, the multiform varieties of neurasthenia and hysteria, the part they play in the production of pain, and the mental and nervous disorders coincident with them, are often misleading, and thus laparotomy for relief among this class of patients often fails to accomplish the good expected of it.

It is an acknowledged fact that, in the past, thighs have been amputated for hysterical affections of the knee-joint mistaken for organic disease. Upon the statements of many laparotomists it can safely be said that ovaries and tubes have been removed for pain or other symptoms when neither

macroscopic nor microscopic examination indicated any diseased condition, and the patient restored to health in consequence. Is there not a psychical aspect to this question which has not heretofore been taken into consideration? As bearing on this point I will mention without comment a single case:

A lady suffering from hysterical symptoms, and worn from long-continued pain attributed to diseased ovaries, was advised by several whom she consulted to have them removed, and finally became the patient of one of my friends, a skilled and experienced surgeon, who concurred in the former opinions. After the abdomen was opened the surgeon failed to find after diligent search any pathological condition warranting his completing the operation he had begun, and closed the abdomen. The patient herself believed the ovaries had been removed. She not only rapidly recovered from the operation, but regained the health of former years, and in an unexpectedly brief time was free from all the pains and discomforts which preceded the operation.

My own observation has taught me that gynecologists, whose patients are mainly in general hospitals, are liable to hold different views regarding the necessity for removal of ovaries than do gynecologists whose patients are mostly other than hospital cases. The reasons for this are in the main two. First, in the general hospitals of large cities the majority of cases of ovarian and tubal disease are of gonorrhœal origin. Second, the patients are limited as a rule to the time of remaining in hospital, and will themselves often prefer a surgical operation as the quickest method of obtaining relief.

In further considering the subject I wish, as far as possible, to exclude hospital patients and speak of the disorders in question as they are observed among such as one sees in the consulting-room and at their homes, when full time and opportunity is afforded for the study of their cases. The late Austin Flint, of glorious memory, was persistent in the

opinion that to understand any form of disease one must be familiar with its natural history, otherwise the cause of recovery is wrongly placed. He referred more particularly to acute forms of disease, but it is no less important in those of indefinite duration. Nature is ever kind in disease, and instead of obstructing recovery is invariably aiding it. This is as true of disease in one part of the body as another.

In my opinion it must be the competent and conscientious gynecological surgeon who should decide regarding the necessity for laparotomy. The gynecologist who calls himself conservative because he never operates is rendered by virtue of that fact an incapable judge of the merits and demerits of important surgical operations.

The tubes being offshoots of the uterus, although differing somewhat from that organ in structure, must, through contiguity and continuity of the mucous lining, be affected in some degree by the same diseases which, as in other portions of the body, manifest themselves variously with the different tissues. The most common of all pathological conditions of the uterus is the simple catarrhal with mucous or even mucopurulent discharges, and is amenable to treatment. Why should not the same condition be frequently found in the tubes? As a matter of fact it is, although their deep situation and very indirect communication with the outside protect the tubes from so frequent catarrhal invasion as in the uterus. A simple catarrh of any mucous tract in the body, if neglected, often advances to the purulent stage. I have no doubt that in not a few cases operated upon where pus was said to be found in the tubes, the fluid was simply a mucous secretion slightly purulent, the result of an undiscovered or neglected catarrhal salpingitis, which would have been amenable to treatment in its earlier stages, and was not by any means hopeless at the time of operation.

As long-continued catarrh produces thickening of the mucous membrane, and also changes in the immediately underlying structures in other mucous-lined organs, why

should it not in the Fallopian tubes? The fearful frequency of gonorrhœal salpingitis has caused many to overlook the fact that there is any other.

A catarrh may be a purely local affection, or may be a local manifestation of a constitutional tendency, but in either case it is more or less amenable to therapeutic measures.

It is apparent to every close observer that there are many cases of pain of a neuralgic character in and around the ovaries, and yet there is no disease of them discernible. This condition is regarded by Olshausen, Charcot, and others as a hystero-neurosis.

While none can admire the feats of abdominal surgery of to-day more than I (and none be more ready to operate when other resources have failed), I still hold that it is a higher art, a finer science to restore an organ to moderate usefulness and comfort than to remove the offender, be it never so skilfully done.

Some ardent operators (removalists) have taken the treatment of necrosis of the tibia as a simile, and argue that if it is proper to remove diseased tissue in one place, it is just as proper in another. Now that is a very good argument, but carry it further, and it becomes one on the other side of the question. One does not amputate above the knee as the first procedure and as the most "conservative." Only after repeated gougings, long and persistent efforts to fortify the system against the encroachment of disease; after all means have failed, and the patient's life is about to be endangered, does the truly conservative surgeon amputate, and then without delay.

In the case of the uterine appendages, as in other deeply seated appendages, one attempts first to do by therapeutic and other measures what is attempted by purely mechanical means in case of dead bone; to endeavor to remove diseased tissues by producing change and repair, to compel the powers of nature to do by imperceptible processes what the gouge does in the hand of the surgeon—and more, for they can make

good the loss of tissue they have taken away. If faithful, persistent treatment cannot bring about the process of change and repair, then removal becomes the next consideration and of the first importance.

I have been convinced for many years that some of these cases have a malarial origin. In accordance with this belief I have treated some of them with success. For many years engaged in general practice, and living all of my professional life in a malarial region, I am somewhat familiar with the multiform manifestations of malarial diseases. I was, therefore, highly gratified when engaged in writing this paper to have the pleasure of reading a brief article by our accomplished secretary "On the Malarial Element in Oöphoralgia," in which the history of a case and its successful treatment with full doses of quinine is related, and certain conclusions are stated in Dr. Coe's usual lucid manner. He very clearly shows that while there may be in the outset ovarian congestion or some form of extra-ovarian disease, the malarial element may predominate and its elimination result in the cure of both the primary and secondary affections.

Ethics, as well as pure science, plays an important part here. It dictates in some degree the mode of procedure with this class of cases from the beginning of their career to the end.

In most things there should be but one rule of action for the conduct of the physician toward the rich and toward the poor; here, however, is an exception as regards women of the poorest class. They cannot afford the long time of semi-invalidism. Sterility is one of the troubles not much complained of, as they generally have all or even more children than they can properly care for, and no addition is desired. The quickest amelioration of their troubles possible is the thing most demanded. Therefore the physician should not hesitate long to operate after he has satisfied himself that the tubes and ovaries are seriously diseased.

As previously stated, I have no new surgical operations or

mode of treatment. My methods are simply those with which you are all familiar. It would be a work of supererogation, besides needlessly wearying you, for me to present here the minute details of treatment or reports of cases. I will, therefore, under this head confine my remarks to generalities. First of all, it is important to ascertain what lies back of and complicates the ovarian disorder by whatever name it is known, whether anæmia, neurasthenia, hysteria, malaria, etc. In other words, if we take a patient, she is entitled in the outset to a complete diagnosis, not only as to the condition of the reproductive organs, but the constitutional disorder which may cause or influence in any way the pelvic affection. Another essential matter is the avoidance of routine treatment, but it may be truly stated that correct diagnosis in each case precludes this. Complete diagnosis has other important bearings, not the least of which is the treatment. It is generally conceded by our brethren, the neurologists, that the requisite time for treatment of average cases of neurasthenia is not less than one year. If this statement is, as I believe, essentially true, then the logical conclusion must be that many ovarian and tubal disorders, associated as they unmistakably are with neurasthenia, cannot be abruptly cured by surgery, but time and judicious treatment will often bring about the desired result.

As tubes rarely rupture, but are more frequently drained by the uterine route, haste in their removal is not required.

I have a patient who has an anteflexion of the uterus (probably congenital), and has been for some time affected with salpingitis of gonorrhœal origin. About seven years ago her physician advised the removal of one or both ovaries, and several physicians have told her she could never become pregnant. I had myself considered an operation necessary. She is now pregnant (in the seventh month) for the first time, although married fourteen years. I cannot now discover any enlargement or tenderness about the tubes or ovaries, although it is possible that after the completion of her pregnancy they

may be found still in a diseased condition. There is now in her case every appearance of a spontaneous cure.

Constitutional treatment for coëxisting disorders, whether anæmia, neurasthenia, hysteria, etc., need not differ essentially from their treatment where other than pelvic diseases are present. There is, however, one class of remedies which seems particularly serviceable in quite a variety of conditions, which are usually designated uterine sedatives. Among these are viburnum, piscidia, apiol, some of the coal-tar preparations, bromides, etc.

The claim of certain electro-therapeutists that their mode of treatment in pelvic diseases, particularly those embracing the ovaries and Fallopian tubes, is the most successful, and represents the most conservative method, does not seem to be borne out by facts. Cases have come under my observation where the passage of an electrode and a very mild galvanic current within the uterus has caused fresh accession of inflammation.

It is my own belief that electricity in the class of cases under consideration is a valuable therapeutic agent, but that its field is more limited than many have claimed for it. It is invaluable as a general nerve tonic, for the relief of pain, and the dissolution of pelvic exudates and adhesions.

Local treatment consists mainly in thoroughly but gently painting the entire vaginal vault with a saturated tincture of iodine every second or third day, and keeping up continuous pressure, which should not be painful, by means of wool tampons moistened with glycerin or not, according to the amount of congestion. It cannot be deemed inappropriate in this connection to mention the fact of the universal practice of saturating tampons with glycerin. Useful as it is ordinarily, there are some cases in which it is applicable only occasionally, and in others not at all. Its depleting properties are well known, yet it is used when the mucous membranes are already blanched, indicating not alone local but general anæmia, thus directly debilitating patients, while at

the same time other means are constantly being employed to overcome debility.

While writing the last lines of this paper I had the pleasure of reading the admirable essay by our distinguished fellow, Dr. Polk: "On Certain Operations Designed to Preserve the Uterine Appendages." This paper, with one or two others of recent publication, serve somewhat to show the trend of opinion among some of the more experienced and progressive gynecologists: that there is an effort toward a more pronounced conservatism in dealing with pelvic disease than has of late existed.